| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 106011 | A. Building<br>B. Wing | 02/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Kissimmee Nursing & Rehabilitation Center | 2511 John Young Parkway North<br>Kissimmee, FL 34741 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192<br><br>Based on observation, interview, and record review, the facility failed to promote dignity in dining for 1 of 4 residents reviewed for dignity, of a total sample of 59 residents, (#51).<br><br>Findings:<br><br>Review of resident #51's medical record revealed she was initially admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia, and anxiety.<br><br>Review of resident #51's Minimum Data Set quarterly assessment with Assessment Reference Date of 12/6/24 revealed a Brief Interview for Mental Status score of 3 out of 15, which indicated severe cognitive impairment.<br><br>On 2/26/25 at 3:23 PM, Certified Nursing Assistant (CNA) H explained the interventions in place to assist resident #51. During the conversation, CNA H described resident #51 by saying, she is a feeder. CNA H affirmed that was the term used to refer to the residents who required assistance eating. CNA H asked, Should we not call them like that? Later, on 2/27/25 at 1:59 PM, CNA H repeated, She is a feeder while pointing to the eating section of the Kardex (plan of care) describing the care for resident #51.<br><br>On 2/28/25 at 8:05 AM, the Director of Nursing stated CNAs should not refer to resident as feeders. She acknowledged using those terms as, A dignity issue.<br><br>Review of the CNA Competency form signed by CNA H on 2/20/25 revealed she passed the required competencies for her job. The form listed Dignity and Individuality and read, C.N.A. maintains and enhances a patient's self-worth.<br><br>Review of the facility's policy titled Promoting/Maintaining Resident Dignity revised on 4/01/24 revealed an intent to protect and promote resident rights and to treat each resident with respect and dignity. |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51023<br><br>Based on interview, and record review, the facility failed to notify emergency contact and Power of Attorney of changes in medication for 1 of 1 residents reviewed for notification of emergency contact, of a total sample of 59 residents, (#20).<br><br>Findings:<br><br>Resident #20 was admitted to the facility on [DATE] with diagnoses including epilepsy (seizures), hemiplegia and hemiparesis following cerebral infarction (stroke) affecting left non-dominant side, dementia type 2 diabetes, altered mental status, adjustment disorder with mixed anxiety and depressed mood, and personal history of traumatic brain injury. The Admission Record contained essential information including resident #1's selected emergency contacts with their associated telephone numbers. The document listed the resident's son as emergency contact #1 and the healthcare Power of Attorney. Resident #1's daughter was emergency contact #2.<br><br>The hospital transfer form dated 1/23/25 revealed that resident #20 required a surrogate when making healthcare decisions and his cognitive status was alert, but disoriented and could not follow simple instructions.<br><br>Review of a psychiatry consult from 1/27/25 revealed resident #20 was alert and oriented to self only. He believed he was in the dome and waiting for his bus at the time of the evaluation. The resident was unable to participate in a meaningful conversation. He had poor judgement and insight as well as impaired short and long-term memory.<br><br>A social service progress note on 1/28/25 revealed resident #20's son, who was his healthcare surrogate/POA, was contacted to discuss the resident's discharge plan due to the resident having a Brief Interview for Mental Status (BIMS) score of 3/15 which suggested severe cognitive impairment.<br><br>Review of hospital discharge paperwork from 1/23/25 revealed a physician's order for Depakote Sprinkles DR 125 milligrams (mg) capsules with 2 capsules (250mg) in the morning at 9:00 AM, 4 capsules (500mg) at lunch time at 2:00 PM, and 4 capsules (500mg) at bedtime at 9:00 PM for seizures.<br><br>Review of resident #20's Electronic Medication Administration Record (EMAR) revealed an order for Depakote DR 125mg, 2 tablets by mouth three times a day with a start date of 1/24/25 at 9 AM. Resident #1 received the 9:00 AM dose on 1/24/25 as was ordered at that time then the order was corrected by the physician to read 250mg in the morning and 500mg at lunch and bedtime as reflected in the hospital discharge paperwork.<br><br>Review of resident #20's physical chart revealed a handwritten physician order sheet dated 1/27/25 reading change Depakote order to 750mg every 12 hours with a diagnosis of epilepsy. This order was given over the phone by the Medical Director's PA. The order was received by the Unit Manager of the Specialized Subacute Unit (SSU). Resident #20's EMAR reflects this change.<br><br>(continued on next page) |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Depakote is a medication used to treat various types of seizure disorders by affecting chemicals in the body that may be involved in causing seizures (retrieved from www.drugs.com/depakote on 3/14/25).<br><br>On 2/27/25 at 6:00 PM, resident #20's son and health POA revealed the neurological medication his father was discharged from the hospital on was changed by the facility's physician without the family's notification. He explained the Neurologist at the hospital had worked out a dosing and timing schedule that the family felt was appropriate. Resident #20's son said the family visited daily and the change in the medication affected their father's alertness and ability to participate in physical therapy.<br><br>On 2/28/25 at 4:40 PM, the Unit Manager (UM) of the Specialized Subacute Unit (SSU) revealed the change in resident #20's Depakote was made to try and taper the medication. She acknowledged they did not notify resident #20's son of the change in medication. The UM stated she could not find documentation regarding a notification to family of the Depakote change in the resident's clinical record.<br><br>Facility policy titled Notification of Changes revised 4/01/24 indicated when a resident was incapable of making decisions the representative would make any decisions that had to be made. |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192<br><br>Based on observation, interview, and record review, the facility failed to ensure a resident was evaluated for safe self-administration of medications for 1 of 2 residents reviewed for choices, of a total sample of 59 residents, (#5).<br><br>Findings:<br><br>Review of resident #5's medical record revealed she was initially admitted to the facility on [DATE] and readmitted from a short-term, acute hospital on 2/03/25. Her diagnoses included coronary artery disease, lymphedema, and chronic pain syndrome.<br><br>Review of the Minimum Data Set (MDS) quarterly assessment with Assessment Reference Date of 12/31/24 revealed resident #5 had a Brief Interview for Mental Status score of 15 out of 15 which indicated intact cognition. The MDS assessment noted rejection of care necessary to obtain goals for her health and well-being occurred 4 to 6 days, but less than daily, during the look-back period.<br><br>On 2/27/25 at 11:06 AM, resident #5 was observed in bed with a medication cup containing various pills on her bedside table, along with a breakfast tray. There was no staff present in the room at that time. A few minutes later, Registered Nurse (RN) D entered the room and asked resident #5 to please take her medications because she could not leave them for her to take later. Resident #5 took the pills and returned the empty medication cup to RN D.<br><br>Review of resident #5's medical record did not reveal a physician order or plan of care for self-administration of medications.<br><br>On 2/27/25 at 11:11 AM, RN D stated she had never left medications at bedside before. She indicated the medications in resident #5's cup included 2 tablets of Tylenol, and one of each of the following Bupropion, Stool Softener, Midodrine and Methocarbamol, for a total of 6 pills. RN D said resident #5 always wants to keep the meds. RN D validated she stepped out of the room and left the medication with resident #5 as she had not yet taken the medication. RN D explained she had not mentioned to the Unit Manager (UM) or Director of Nursing (DON) resident #5's request to keep her medications and take them later herself. She descibed how she stepped out of the room to ensure her medication cart was locked. RN D said, Everybody knows about her. She wants to keep all her meds; she wants to take time and that is why we give her meds last.<br><br>On 2/27/25 at 12:46 PM, the General & Restorative Unit UM stated it was acceptable to leave medications at bedside, as long as the resident is coherent and there is no narcotics. She shared she has personally done the same the thing but not at this facility. The UM stated RN D went back to the room and collected the cup. The UM said, You cannot force the patient to take the pills right that second. When asked about the facility's policy for medications left at bedside, she responded she did not know if there was a process to it here.<br><br>(continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/27/25 at 2:53 PM, the DON stated she spoke with RN D who validated she turned her back and left resident #5 with the cup of pills. The DON validated RN D was not supposed to leave medications in resident #5's room without being present when she took them. The DON stated a nurse could not leave any medications at bedside and must witness when the resident took the medication.<br><br>Review of the facility's policy titled Resident Self-Administration of Medication revised on 3/01/24 revealed an intent to support each resident's right to self-administer medication. The policy read, A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. The policy guidelines included each resident was offered the opportunity to self-administer medications during routine assessment by the interdisciplinary team and the resident's preference would be documented on the appropriate form and placed in the medical record. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192<br><br>Based on observation, interview and record review, the facility failed to report allegations of abuse and neglect to the State Agency (SA) and protect the resident during the investigation for 1 of 2 residents reviewed for abuse, of a total sample of 59 residents, (#56).<br><br>Findings:<br><br>Review of resident #56's medical records revealed she was originally admitted to the facility on [DATE] and readmitted from a short-term, acute hospital on 1/01/25. Her diagnoses included paraplegia (paralysis that affects the lower half of the body), anemia, psoriasis (skin disorder), major depressive disorder, and coronary artery disease.<br><br>Review of resident #56's Minimum Data Set (MDS) quarterly assessment with Assessment Reference Date of 12/02/24 revealed a Brief Interview for Mental Status score of 15 out of 15 which indicated intact cognition. The MDS assessment noted her primary language was Spanish, and she wanted an interpreter to communicate with a doctor or health care staff. The Mood section revealed resident #56 experienced social isolation often. The MDS assessment noted rejection of evaluation or care necessary to obtain goals for health and well-being from 1 to 3 days. Resident #56 had lower extremities impairment and was dependent on staff for toileting, showers, personal hygiene, and putting on/off footwear. She was always incontinent of bladder and bowel.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/24/25 at 12:06 PM, an interview was conducted with resident #56 in Spanish. Resident #56 explained she had been a resident of this facility for over two years. She shared a recent problem with a nurse who, during the night medication pass, brought her a medication that had been discontinued and another medication she wanted to take every other night. She stated the pills were brought in a cup. She explained she took the discontinued pill out of the cup and told the nurse that medication was discontinued two weeks before. She shared that nurse only spoke English and she spoke very little English, so she tried her best to explain she was not taking that pill and pointed to another in the cup explaining she had told nurses before she only wanted to take it every other night. She indicated while she was talking to the nurse one of the pills fell on the floor and the nurse picked the pill from the floor and placed it back in her cup with the other medications. Resident #56 stated she asked the nurse why she placed the pill from the floor in her cup and that she was not supposed to do that. The resident explained she asked the nurse for a supervisor. She indicated the nurse was visibly agitated and raised her voice at her. Resident #56 showed a picture she had of the two pills. One pill was white and elongated and the resident stated that was Atorvastatin 80 milligrams (mg). The other medication was a yellow and blue capsule which the resident indicated was used to treat depression. She explained she told the psychiatry nurse practitioner she no longer wanted to take it, and it was discontinued. She stated she took the medications in the cup that night except for the 2 pills which she kept. She stated the nurse asked to return the 2 pills she did not take, and she told the nurse she would not return the pills to her until she spoke with a supervisor. She indicated the nurse left the room and did not bring or call a supervisor. She mentioned she felt sad and disappointed because she expected a different attitude from the nursing personnel. She indicated after the nurse left her room, she overheard the nurse yelling at a resident in another room. Resident #56 stated that night she cried and could not fall asleep. She indicated the worst happened the next morning. She recalled she spoke with MDS Coordinator L early the next morning and asked her to get someone who spoke Spanish and could translate what she wanted to share. She stated MDS Coordinator L brought someone who spoke Spanish, and she explained what happened the previous night. She stated MDS Coordinator L notified the management about the incident. She mentioned shortly after she spoke with MDS Coordinator L, the Director of Nursing (DON) came to her room screaming at her and calling her a liar because, according to her, the discontinued medication was not in the medication cart. She indicated the DON came in with the night nurse and each one insulted her and asked her for the pills she kept. Resident #56 stated she told them she would not return the pills because that was her evidence and without it, she would have no proof of what happened. She mentioned she could not eat all day, and she was nervous and upset. She shared after that encounter, she called the state's Department of Children and Families (DCF), and a DCF investigator visited her the same day. She indicated after she showed the pills to the DCF Investigator, who took pictures of the pills, she handed them to Licensed Practical Nurse (LPN) I. She stated she told the DCF Investigator the DON and the nurse yelled at her and were disrespectful to her. She shared she had called DCF a few weeks prior to report concerns about other residents who did not get personal care all day and a DCF Investigator visited the facility at that time and spoke to those residents directly. She shared she was now labeled as problematic. She also shared an incident with a Certified Nursing Assistant (CNA) who did not change her for hours and she was wet and uncomfortable. She indicated on that occasion, a male nurse came to her room around 9:00 PM and after explaining the situation to him, he asked the CNA to change her but the CNA responded she was not assigned to resident #56. She indicted the male nurse had to find another CNA to change her. She stated after the CNA changed her, the Night Supervisor told her she did not have an assigned CNA, she was not a priority at the facility, and the priority was her roommate. She shared she preferred Spanish speaking staff to ensure there was no miscommunication. She also shared Registered Nurse (RN) P, the nurse who gave the wrong medication and yelled at her, was assigned to her again even though she was told by the DCF Investigator that she had told the facility the nurse could not get close to her again. She mentioned she had told a Spanish speaking staff she did not want that nurse assigned to her again. She shared RN P came to her room a few days after the pill incident and asked for her finger to check her blood sugar. She stated she told RN P to leave her room because she was not supposed to be there again. She stated RN P left the room and made a hand gesture toward her as she left the room. She said that made her cry. She mentioned she was afraid RN P would give her the wrong medication or do something to her in retaliation. She said |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Reportable Log from November 2024 to February 2025 on the first day of survey did not reveal abuse or neglect allegations reported by resident #56.<br><br>Review of DCF reports showed they visited resident #56 at the facility on 11/30/24, 2/04/25 and 2/18/25.<br><br>Review of resident #56's Progress Notes revealed a note entered as a late entry on 2/24/25 by RN A dated 2/21/25 which read, On Friday February 21, 2025 I did not touch the resident to do anything for her because she did refused my service while I was by the resident door. I called a coworker from medical record, the coworker translate for me, then I called the supervisor, the supervisor was the one taking care of her.<br><br>On 2/24/25 at 1:36 PM, the Administrator (NHA) stated the DON and her were the abuse coordinators. The surveyor reported the allegations of verbal/emotional abuse from resident #56 to the NHA. The NHA stated no one had yelled at resident #56. The NHA shared resident #56 was admitted before she came to the facility. She shared since resident #56 applied for Medicaid and lost her Social Security Disability benefits, she was mad and often complained about the food and care. She indicated resident #56 would complain to the State if she did not get what she wanted and accused staff. She mentioned she had done multiple reportable and grievances on her. The NHA said resident #56 got mad and complained about no one changing her. She stated she interviewed everyone. The NHA shared resident #56 had a concern with medications and kept two pills and She constantly says she is calling the state. The NHA confirmed DCF came out for her last week. She stated the DCF Investigator mentioned it was about medications and not being changed. The NHA said That would not be neglect, she didn't use the work neglect. She recanted her statement and added she did not feel the time frame would be neglect because the CNA told resident #56 she would come at 8:00 PM to change her and the CNA said she was there 10 or 15 minutes late. She added, If it was 1 to 2 hours wait for care, she would have reported it. She stated she would start reporting every time DCF came to the facility. She recalled DCF was there twice, but the DCF Investigator did not mention anyone yelling at resident #56. She mentioned she would find out who translated for the DON when she spoke with resident #56. She stated a reportable was done on 2/04/25 for another resident and resident #56. Later at 2:04 PM, the NHA asked if resident #56 mentioned the DON was yelling as well as the nurse because she would have to suspend her and do the reportable. She showed she submitted a reportable on 2/10/25 when DCF came to the facility for another resident. She then confirmed there was no report submitted for resident #56's allegation of abuse and neglect this month.<br><br>On 2/25/25 at 9:04 AM, resident #56 indicated no one translated for her when the DON and RN P were yelling to her. She repeated about three days later after the incident, she was again assigned RN P after telling them she did not want that same nurse assigned to her. She stated the Specialized Subacute (SSU) Unit Manager (UM) took over for RN P that day and gave her medications.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/25/25 at 1:53 PM, the NHA said she has been handling abuse for a while. She shared she had a grievance from resident #56 on 2/17/25 about a CNA being 15 minutes late and them offering resident #56 a private room because she liked to keep her room at 60 degrees, and they have people wanting to leave out of her room for that reason. She explained on 2/18/25 morning she complained about the pill being dropped and the nurse tried to give her the pill. She stated DCF came a couple of hours after that, but it was not about the pill. She recalled the DCF Investigator asked questions about resident #56, requested a face sheet and went to interview the resident. She stated she did not submit a reportable to AHCA because she did not know what DCF came here about. The NHA showed the Notice to Subjects form left by DCF, which showed a report number and the names and phone numbers for the DCF Investigator and supervisor.<br><br>On 2/26/25 at 12:30 PM, LPN I stated she was very familiar with resident #56 and have never had any problems with this resident. She shared she had instructed the resident to let staff or management know if she had any issues, but the resident preferred to wait for her to share her concerns. LPN I said, She is an easy to take care of resident. She explained she received report from RN P on 2/18/25 that resident #56 alleged a medication was dropped on the floor and she gave her a medication that was discontinued. She stated resident #56 complained about RN A that morning and mentioned she did not want RN A to take care of her again. LPN I stated resident #56 showed the pills she kept and gave them to her after she spoke with the DCF Investigator. LPN I explained she had translated for the DON and RN A in the room with resident #56 and RN A called LPN I a liar, but she was translating, not accusing her. She shared RN A said someone must have given the resident those medications to get her in trouble. She explained while translating in the room for the DON and RN A, resident #56 was crying and wanted to get out of bed. She recalled RN A spoke to resident #56 with an attitude, accusing the resident she was lying. She stated RN A denied the medication was dropped on the floor and stated she discarded the medication the resident refused. She stated she asked RN A to leave the room because of the disrespectful tone used toward resident #56. She indicated the DON told the resident she would investigate her concerns. LPN I stated the DON was already in resident #56's room before she got there to translate and the resident was already agitated by the time she arrived. She recalled on 2/18/25 she told administration resident #56 requested they not assign RN P to care for her again.<br><br>On 2/26/25 at 1:17 PM, MDS Coordinator L shared she performed daily visits to her assigned residents for mock survey which included resident #56's room. She recalled resident #56 called her into her room early one morning because she was upset with the nurse assigned to her. MDS Coordinator L stated resident #56 asked her to let the NHA know but explained it was approximately 6:30 AM and she spoke with the Night Supervisor instead. She shared she could tell resident #56 was upset, not crying, just frustrated, angry. She stated LPN I translated for her and the Night Supervisor when resident #56 shared what happened during the night. MDS Coordinator L reflected she had never had problems with (resident #56) at all in the many years together.<br><br>On 2/27/25 at 9:13 AM, during a telephone interview, the DCF Investigator confirmed she visited resident #56 last week. She explained every time DCF came to a facility they discussed the allegations with the facility representative during their entrance conference. She recalled mentioning to the NHA resident #56's report about the supervisor screaming at her.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/27/25 at 3:19 PM, the DON stated the Night Supervisor called her at around 6:00 something on 2/18/25 to report the incident with resident #56. She recalled she talked to resident #56 that morning and asked the resident what happened. She recounted resident #56's complaint about a pill that was dropped on the floor and showed her the two pills, the one dropped to the floor and one that was discontinued. She stated she told resident #56 to give her a moment to talk to the nurse and left the room to investigate what happened. The DON indicated she spoke with RN A and confirmed the discontinued medication was not in the medication cart. The DON mentioned after speaking with the nurse, she returned to resident #56's room with RN A and LPN I. The DON stated RN A denied resident #56's allegation and was upset when she started asking questions, while resident #56 was crying. She indicated LPN I translated while consoling resident #56. The DON instructed RN A to write a progress note.<br><br>On 2/27/25 at 5:50 PM, the SSU UM confirmed she took over the care of resident #56 one day last week when the resident did not want RN P, her assigned nurse. She stated she had not done the assignment.<br><br>On 2/28/25 at 2:43 PM, the NHA repeated the DCF investigator did not inform her of the reason of her visit on 2/18/25. She confirmed DCF visited the facility 2/04/25 but it was not in reference to resident #56. She stated she did not remember a visit from DCF to resident #56 on 11/30/24. She said at her former building they did not report the DCF visits. She indicated she was told DCF reported their visits to the SA and was not given a directive by this company. She stated she did not remember anything about her conversation with the DCF investigator on 2/04/24 except he mentioned resident #56 had an issue with food and she sent the Dietary Manager to speak with the resident. She stated the DCF Investigators did not share the allegations, only requested paperwork which she provided, and when they came she was not told, half of the times what their visits were about. She said she reported abuse and neglect for almost everyone. When asked why RN P was allowed to continue working on 2/24/25 until the end of her shift after they were made aware of the allegation of verbal abuse by resident #56, the NHA responded that when she realized RN P was involved in the incident she was suspended. The NHA shared when they identified they had assigned the same nurse to resident #56 last week, she was switched to the UM. Later at 4:05 PM, the NHA explained the DON was suspended on 2/24/25 and brought back the next day because she was able to rule out quickly she did not yell at resident #56.<br><br>The facility's policy Abuse, Neglect and Exploitation, implemented 3/01/22 and reviewed/revised on 3/01/23 revealed how to prevent, identify, investigate, protect residents and report allegations. The guidelines mentioned the facility would designate an Abuse Prevention Coordinator who was responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. The facility's policy instructed facility staff on the investigation of different types of alleged violations, and read, Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; . Providing complete and thorough documentation of the investigation. |

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| Kissimmee Nursing & Rehabilitation Center | 2511 John Young Parkway North<br>Kissimmee, FL 34741 |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40892<br><br>Based on interview, and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected fall with major injury status for 1 of 4 residents reviewed for falls, of a total sample of 59 residents, (#109).<br><br>Findings:<br><br>Resident #109's medical record revealed he was initially admitted to the facility on [DATE] and readmitted from an acute care hospital on 2/11/25. His diagnoses included osteomyelitis (bone infection), difficulty walking, and femur fracture.<br><br>On 2/24/25 at 11:40 AM, resident #109 stated he fell coming out of the bathroom about 3 weeks ago, and broke his right femur; he said he was transported to the hospital but did not have surgery.<br><br>Review of resident #109's MDS Discharge Assessment with an Assessment Reference Date (ARD) of 1/25/25 and a 5-day assessment with an ARD of 2/18/25 revealed that his fall status was incorrectly assessed.<br><br>On 2/27/25 at 5:15 PM, MDS Transitional Nurse K explained he was responsible for completing this MDS. He acknowledged both MDS's did not indicate under the category of fall with major injury resident #109's fall. He verified the information submitted in the MDS was not accurate. He said he reviewed hospital documentation before completing the MDS assessment and care plan.<br><br>Review of the Centers for Medicare & Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual Section J: Health Conditions, Pain, Shortness of Breath, Prognosis, Problem Conditions, and Falls. The manual revealed coding instructions for section J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment. The instructions directed the user to code the number of falls, major injury-bone fractures, joint dislocation, closed head injuries with altered consciousness, and/or subdural hematoma (brain bleed). The directions continued, Review any follow-up medical information received pertaining to the fall, even if this information is received after the ARD (e.g., emergency room x-ray, Magnetic resonance imaging (MRI), Computed tomography (CT) scan results), and ensure that this information is used to code the assessment.<br><br>The facility's policy and procedure, MDS 3.0, was reviewed on 1/01/24. The document read, 1. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate, and standardized assessment of each resident's functional capacity, using the RAI specified by the State. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40892<br><br>Based on observation, interview, and record review, the facility failed to ensure an individualized comprehensive care plan was implemented for 1 of 1 resident reviewed for seizure safety precautions, (#92); and for 1 of 2 residents reviewed for communication, (#56), of a total sample of 59 residents.<br><br>Findings:<br><br>1. A review of the medical record revealed resident #92 was admitted to the facility on [DATE] with diagnoses that included hydrocephalus (fluid on the brain), epilepsy (seizure disorder), autistic disorder, speech disturbances, and mood disorders.<br><br>The Minimum Data Set (MDS) Annual assessment with an assessment reference date (ARD) of 12/11/24 revealed resident #92 had a Brief Interview for Mental Status (BIMS) that could not be conducted as the resident was rarely or never understood.<br><br>A review of the resident's medical record revealed current comprehensive care plans with a focus on seizure disorders related to epilepsy. Interventions included seizure medication as ordered and padding to side rails.<br><br>On 2/26/25 at 3:10 PM, resident #92 was lying in bed but the rails of the bed were not padded for safety in case of seizure. On 2/27/25 at 10:02 AM, assigned Certified Nursing Assistant (CNA) Q verified the resident's unpadded rails. CNA Q stated she did not know why the pads were in the corner of the room and not on the bed. She did not know who put them there.<br><br>On 2/27/25 at 10:04 AM, the Geriatric and Restorative Unit Manager stated the bed rails were only padded at night because that was when the resident got agitated.<br><br>On 2/27/25 at 4:31 PM, the Director of Nursing stated she expected the staff to review resident's care plans and implement the listed interventions.<br><br>43192<br><br>2. Resident #56 was initially admitted to the facility on [DATE] and readmitted from an acute care hospital on 1/01/25. Her diagnoses included paraplegia (paralysis that affects the lower half of the body), anemia, psoriasis (skin disorder), major depressive disorder, and coronary artery disease.<br><br>Review of the MDS quarterly assessment with Assessment Reference Date of 12/02/24 revealed resident #56 had a Brief Interview for Mental Status score of 15 out of 15 which indicated intact cognition. The MDS assessment noted her primary language was Spanish, and she wanted an interpreter to communicate with a physician or health care staff. The Mood section revealed resident #56 experienced social isolation often. The MDS assessment showed resident #56 had lower extremities impairment and was dependent on staff for toileting, shower, personal hygiene and putting on/off footwear. She was always incontinent of bladder and bowel.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of resident #56's care plan did not include a focus on communication, resident's primary language or her desire for an interpreter to communicate with a doctor or health care staff, as indicated by the MDS assessment.<br><br>On 2/24/25 at 12:06 PM, interview with resident #56 was conducted in Spanish. She explained she recently had a problem with a nurse who gave her a medication that was discontinued and another medication she refused to take. She shared she took one pill out and tried to explain to the nurse in her little English that medication was discontinued 2 weeks prior. She added she showed the nurse another pill she only wanted to take every other night. She explained during the conversation one pill fell on the floor and the nurse picked it up from the floor and placed it back in her cup. Resident #56 stated she asked the nurse why she did that and that she was not supposed to place a pill that fell on the floor back in her cup. The resident indicated when she requested to speak with a supervisor, the nurse got agitated and raised her voice at her. The resident stated a supervisor did not visit her that night, she cried and could not sleep. She mentioned she preferred to be cared for by Spanish speaking staff and had communicated her choice previously to the staff.<br><br>On 2/26/25 at 12:30 PM, Licensed Practical Nurse (LPN) I stated she was very familiar with resident #56. She shared she had never had any problems with this resident as she communicated with her in Spanish. She indicated she had instructed resident #56 to let staff or management know whenever she experienced any issues. LPN I shared resident #56 usually waited for her to share her concerns because she felt comfortable with her.<br><br>On 2/26/25 at 1:17 PM, MDS Coordinator L indicated when a resident's primary language was not English, she added a communication care plan. She shared she knew resident #56 for as long she had lived in the facility. She shared resident #56 could say a few words in English and could understand English better than she could speak it. She explained when she talked with resident #56, the resident would let her know to get someone to translate when they could not understand each other. MDS Coordinator L looked through resident #56's care plan, including resolved focus areas and interventions and validated there was not one for communication. She indicated one should have been created. She stated they reviewed the care plan every quarter and resident #56 attended the meetings which were held in her room. She shared there was always someone in the meeting who spoke Spanish. MDS Coordinator L reviewed the quarterly MDS assessment dated [DATE] and acknowledged resident #56 expressed her desire to have an interpreter when communicating with physicians or health care staff.<br><br>Review of the policy titled Comprehensive Care Plans revised on 1/01/23 revealed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs that are identified in the resident's comprehensive assessment. The guidelines revealed the care planning process included an assessment of the resident's strengths and needs, incorporating the resident's personal and cultural preferences in developing goals of care. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192<br><br>Based on observation, interview, and record review, the facility failed to revise and implement appropriate interventions including the provision of adequate supervision to prevent falls for 2 of 4 residents reviewed for falls, of a total sample of 59 residents, (#3 and #51).<br><br>Findings:<br><br>1. Review of resident #3's medical record revealed she was originally admitted to the facility on [DATE] and readmitted from a short-term, acute hospital on 8/14/24. Her diagnoses included senile degeneration of brain, type 2 diabetes, dementia, glaucoma, bilateral hearing loss, and congestive heart failure.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of 12/10/24 revealed resident #3's Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated severe cognitive impairment. The MDS assessment showed resident #3's hearing was highly impaired, and her vision was impaired. She required supervision for eating, and substantial assistance from staff for toileting, lower body dressing, upper body dressing, putting on/taking off footwear, and personal hygiene. She was dependent on staff for showers. The MDS assessment revealed resident #3 required supervision or touching assistance for rolling left and right, sit to lying, lying to sitting, and to wheel up to 150 feet in the wheelchair. She required substantial assistance for sit to stand, chair/bed-to-chair transfer and from a bed to chair (or wheelchair), toilet transfer and tub/shower transfer. Walking was not attempted due to medical condition or safety concerns. She was frequently incontinent of bladder. Since the previous MDS assessment, she had one fall with no injury.<br><br>Review of resident #3's comprehensive care plan revised on 8/26/23 revealed a focus of risk for falls. Interventions included to anticipate and meet the resident's needs and encourage her to use the call light for assistance as needed. A care plan for cognition revised on 8/26/23 directed staff to Cue, reorient and supervise as needed. A care plan for a behavior problem related to urinating in inappropriate places specifically the trash can was initiated 11/19/24. The interventions directed staff to offer and escort the resident to the toilet frequently and to remove the trash container from her room/area. A communication problem due to a language barrier care plan revised 5/25/24 revealed resident #3 spoke Spanish and had hearing loss.<br><br>Review of resident #3's medical record revealed the following Change in Condition Evaluations:<br><br>*2/18/25 fall with injury, bump on forehead<br><br>*2/13/25 bruise in the left eye and swelling<br><br>*2/12/25 fall with no injury<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Falls Investigation Worksheet for the fall on 2/12/25 revealed resident #3's daughter was with the resident at the time of the fall. The form showed the fall occurred in the bathroom and the resident required supervision. The Recommendations/Interventions included assisting the resident to the bathroom after meals, ensure the call light was within reach, educate the family to ask for help toileting, and neurological checks.<br><br>Review of the Falls Investigation Worksheet for the fall on 2/18/25 revealed resident #3's was leaning forward to pick something up from the floor. The form indicated resident #3 required supervision. The form included the number of falls in the last 30 days was 2 and in the past 31-180 days she had two falls. A bump on the forehead was noted. The nurse statement included she called the physician and resident #3 was sent to the hospital for evaluation.<br><br>Review of the following Fall Risk Evaluation form revealed resident #3 scored below 10 on 2/12/25. The Fall Risk Evaluation form read, Total score of 10 or ABOVE represents HIGH RISK. Initiate a Fall Risk Care Plan for High Risk Components/Factors (i.e. Blind, Unsteady Gait, Seizure Disorder) regardless of resident not scoring a 10 or above. The form showed resident #2 was ambulatory and continent. The questions, Walking, turning around and facing opposite direction and moving on and off toilet was answered as Not steady, but able to stabilize without staff assistance. Her vision was incorrectly marked as adequate .<br><br>Review of a Progress Note dated 2/21/25 revealed resident #3 was discussed during the Patient at Risk (PAR) meeting. The note read, Resident continues to be monitored and educated on using call lights to ask for assistance . Another Progress Note entered on 2/21/25 included New intervention: Reinforce to resident to call for assistance to include things fallen on the floor. A Progress Noted dated 2/19/25 read, Despite advising the resident to stay herself in bed for safety and call for assistance the resident does not follow instruction and many times in the frequent rounds the resident has been found standing, walking and making her bed. A Progress Note dated 2/13/25 included resident #3 consistently does not utilize call light as instructed. A Progress Note dated 2/12/25 read, . The resident did not use the call bell to call for assistance.<br><br>On 2/24/25 at 4:04 PM, resident #3 was observed lying in bed on her right side, with eyes closed. A dark purple and light green bruise was noted on her left forehead, measuring approximately 8 x 6 centimeters. There was a trash can next to her bed, and the call light was on the bed rail.<br><br>On 2/25/25 at 10:20 AM, resident #3 was observed sitting on her wheelchair washing her hands in the bathroom sink. When asked in Spanish what happened to her face, she smiled but did not answer. She was wearing slippers.<br><br>On 2/25/25 at 10:21 AM, Certified Nursing Assistant (CNA) J entered resident #3's room. CNA J stated resident #3 fell a few days ago. CNA J stated resident #3 was hard of hearing, wore hearing aids but said they did not work. She shared resident #3 needed supervision.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/25/25 at 10:52 AM, during a telephone interview, resident #3's daughter explained her mother suffered from dementia. She mentioned it had become very dangerous lately because she liked going to the bathroom by herself. She shared her mother had fallen recently in the bathroom and fell again a few days later. Resident #3's daughter said her mother cannot see well, is legally blind, can see shadows, is hard of hearing on both ears, and not even with hearing aids [can she] understand. She does not speak English. She is declining. She stated her mom was sent to the hospital after the last two falls. She indicated she was visiting her mom when she fell in the bathroom, but she did not hurt herself. She recalled a couple of days later, she was called because her mother was sent to the hospital with a big hematoma on her eye. She stated her mom told her she poked her eye and she noticed her mom's eye was swollen and black and blue. She explained she was told the second time her mother fell she bent over to get something from the floor, fell forward and hit herself on the table. She shared the CT scan showed an hematoma outside the skull. She stated she usually did not visit during the day, but her sister and herself visited mostly during dinner to ensure her mother was taken to eat. She shared her mother used to participate in activities, enjoyed coloring books but she had declined a lot. She indicated when she attended Care Plan meetings, she always mentioned concerns about the availability of someone to care for her. She mentioned her mom often refused showers and could go up 2 weeks without a bath, but she received it from CNA H because she is very patient with her, and she talks her into it. Resident #3's daughter stated her main concern was her falls. She said she felt the CNAs did not check on her mother often. She stated her mom would get up unassisted and would not use the call light. She indicated the CNAs should do rounds and checked on her often because her mother still think she can do things by herself.<br><br>On 2/26/25 at 3:08 PM, CNA H stated there was a strong odor of urine in the room because resident #3 urinated on the trash can and on the floor. She explained resident #3 vision and hearing were impaired. She shared resident #3 liked to fix everything by herself, fixes the bed. CNA H stated resident #3's eye looked like someone hit her but she tended to get too close to things to see them and that was probably what happened to her. She stated they tried to place floor mats next to resident #3's bed but resident #3 removed them while she pointed to a floor mat located behind the head of the bed. She explained she checked on resident #3 every time she finished caring for each of her residents because resident #3 liked to fix her drawers and wanted to do things by herself.<br><br>On 2/27/25 at 1:12 PM, the General & Restorative Unit Manager (UM) stated falls were discussed every morning during clinical meetings by the Interdisciplinary Team (IDT). She explained the IDT reviewed the incident report, looked for any type of injuries, and discussed any new interventions required after reviewing the care plan. She indicated any new interventions were added by the MDS Coordinator attending the meeting. She mentioned resident #3's bruise mentioned on 2/13/25 was because of her fall on 2/12/25. She stated resident #3 fell again on 2/18/25 while attempting to reach out for something and was sent out to the hospital. She indicated resident #3 required frequent checks. When asked what frequent checks meant, she explained it was to put eyes on the resident but no specific time frames were required. She indicated a new intervention to offer toileting after meals would show up in the Kardex (care plan used by CNAs).<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/28/25 at 11:56 AM, Registered Nurse (RN) A stated she was not working when resident #3 fell but explained the resident was monitored frequently, every 15 minutes by the CNA and nurses. She indicated resident #3 required one-staff assistance to transfer but the resident transferred herself at times and she did not use the call light. She mentioned resident #3 was disoriented, and could not follow instructions. She shared resident #3's hearing and vision was impaired and although she did not walk, she tried to get up from her wheelchair. RN A stated resident #3 required supervision all day long and a safe environment to avoid falls.<br><br>Review of resident #3's comprehensive care plan did not include resident #3 required frequent, 15 minutes checks.<br><br>On 2/28/25 at 1:25 PM, MDS Coordinator L shared the interventions from the risk management report after the 2/12/25 fall included assistance with activities and monitor for changes. She stated the care plan was updated on 2/13/25 to include Physical Therapy to screen and resident and family education. She mentioned the intervention after the fall on 2/18/25 was to offer resident #3 a reacher and educate her on use. She said she was surprised with the intervention because resident #3 had dementia and her BIMS was very low. MDS Coordinator L validated interventions for frequent supervision or to offer toileting after meals were not included in the care plan.<br><br>On 2/28/25 at 1:50 PM, the Director of Nursing (DON) explained during clinical meeting they reviewed the Fall Investigation Worksheet and witness statements, came up with a root cause for the fall and interventions to prevent future falls. She indicated any interventions they decided would be updated to the care plan if not already there. She read the intervention included on the IDT note dated 2/19/25, Reinforce to resident to call for assistance to include things fallen on the floor and validated it was not appropriate for this resident due to her cognition. She mentioned resident #3 needed frequent checks at least every 15 minutes. She mentioned resident #3 needed to be in a highly visible area to be closely observed by CNAs and nurses to prevent falls.<br><br>2. Review of resident #51's medical record revealed she was originally admitted to the facility on [DATE] and readmitted from a short-term, acute hospital on 2/09/25. Her diagnoses included Alzheimer's disease, dementia, anxiety and insomnia.<br><br>Review of the quarterly MDS assessment with ARD of 12/06/24 revealed resident #51's BIMS score of 3 out of 15, which indicated severe cognitive impairment. The MDS assessment showed no rejection of care necessary to obtain goals for her health and well-being. Resident #51 required set-up for eating and substantial assistance from staff for oral hygiene and upper body dressing. The MDS assessment showed she was dependent on staff for toileting, showers, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS assessment revealed resident #3 required substantial assistance from staff for sit to lying and lying to sitting. She was dependent on staff to roll left and right in bed, sit to stand, chair/bed-to-chair transfer, toilet transfer and tub/shower transfer. Walking was not attempted due to medical condition or safety concerns. She required supervision or touching assistance to wheel 50 to 150 feet in the wheelchair. She was always incontinent of bowel and bladder. Since the previous MDS assessment, she had two falls with no injury.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of resident #51's comprehensive care plan revised on 4/15/24 revealed a focus of risk for falls related to attempt to get up unassisted, confusion, gait/balance problems, incontinence and unaware of safety needs. Interventions included anticipating and meeting the resident's needs and dycem (non-slip pad) to wheelchair. A care plan for impaired cognition revised on 7/26/23 directed staff to Cue, reorient and supervise as needed.<br><br>Review of resident #51's medical record revealed the following Change in Condition Evaluations:<br><br>*2/08/25 - resident found on the floor in the TV room lying on her left side and bleeding on the left side of the forehead. Resident sent to the hospital for evaluation and treatment.<br><br>*12/11/24 - fall with no injury<br><br>Review of the following Fall Risk Evaluation form revealed score below 10.<br><br>*2/08/25 - score of 4. The question if resident had any falls since admission or prior assessment was answered No.<br><br>*12/11/24 - score 9. The question if resident had any falls since admission or prior assessment was incorrectly answered No. Ambulatory and Incontinent were selected.<br><br>Review of the Falls Investigation Worksheet for the fall on 2/08/25 revealed resident #51's unwitnessed fall occurred on the hallway/TV room at 8:35 PM. The question, Did resident require supervision? was answered No. The resident was using a wheelchair. Number of falls in the last 30 days was 1 and number of falls in the past 31-180 days was 2. Resident #51 did not sustain an injury. A Fall Intervention Strategies sheet was attached and listed 51 possible interventions to reduce the risk of falls, but none were selected.<br><br>Review of the Falls Investigation Worksheet dated 12/11/24 revealed resident #51's fall was again in the TV room area when the unwitnessed fall occurred. Wandering was selected as a behavior at the time of this fall. The question, Did resident require supervision? was answered TV. The resident was using a wheelchair. Number of falls in the last 30 days and number of falls in the past 31-180 days was left bank. Resident #51 did not sustain an injury. A Post-Fall Analysis/Review form revealed risk factors of poor safety awareness, history of aggression, and mood worsening in the evening. The analysis included supervision and read, Encouraged to be in common area per plan of care for closer supervision due to poor safety awareness. The possible contributing factors mentioned evening behavioral changes. The interventions to prevent reoccurrence included increased supervision during late afternoon/evening hours, behavioral interventions such as music therapy, sensory activities and environmental modifications in the afternoon/evening.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/26/25 at 3:17 PM, CNA H recalled 2 or 3 Saturdays ago at approximately 8:00 PM resident #51 was in the TV area with other residents. CNA H stated she went to discard soiled linens in the soiled utility room and when she returned resident #51 had fallen from her wheelchair. She shared some time ago the facility used chair alarms, but staff were told they could not use chair alarms any longer. She indicated she found those helpful because staff ran when they heard the alarms. CNA H stated resident #51 used to hit the walls and the physician prescribed a cream to place on her neck which was helpful, but she did not think resident #51 was getting it any longer. She shared resident #51's behaviors changed a lot in the evenings, as she was a sundowner and did not remember anything. She indicated the resident was transferred with a mechanical lift but she thought resident #51 stood up and fell on her right side.<br><br>On 2/27/25 at 1:36 PM, the General & Restorative Unit Manager (UM) stated resident #51's care plan included the use of a dycem when she was in the wheelchair. A few minutes later, at 1:53 PM, while resident #51 was sitting in her wheelchair, the UM checked under the mechanical lift pad and the sides of her seat cushion and stated she could not see the dycem.<br><br>On 2/27/25 at 1:57 PM, Occupational Therapist (OT) M stated dycem was used under the wheelchair cushion to prevent sliding.<br><br>On 2/27/25 at 1:59 PM, CNA H recalled resident #51 had a dycem when she was in another room. She said she was not sure who threw it away because she had not seen the dycem recently. She mentioned the last time she saw the dycem was a month or so ago. She indicated she had not mentioned to anyone about not seeing the dycem because resident #51 was currently working with therapy so they would review the wheelchair and provided a new one if needed. CNA H indicated the dycem was not in resident #51's wheelchair and repeated she did not see it today or any day this past week. When asked to show the safety/fall interventions in resident #1's Kardex (plan of care), CNA H accessed it electronically. She pointed out the safety information, fall interventions or dycem did not appear on the Kardex. She stated she only used the computer to document the care she provided the residents.<br><br>On 2/27/25 at 4:35 PM, the Director of Rehabilitation confirmed resident #51 was currently on OT case load since 2/11/25. She indicated she participated in the clinical meetings. She stated if an intervention for the use of dycem was identified, she placed it in the wheelchair. She explained once the dycem was provided to the resident, it would be nursing's responsibility to continue placing it in the wheelchair. She shared if nursing needed another dycem for a resident, nursing needed to let her know.<br><br>Review of the OT Evaluation & Plan of Treatment for Certification Period of 2/11/25 - 3/12/25 revealed treatment approaches included wheelchair management training. The goals included ability to reposition herself while seated in the wheelchair and increase dynamic sitting balance to facility upright posture. The current referral indicated resident #51 was referred to OT due to fall from the wheelchair. History of falls was answered, No. Her prior level of function revealed resident was dependent with ADL management except feeding and was dependent with mobility and transfers using a mechanical lift. Her safety awareness was identified as intact. The clinical impression read, Patient exhibits new onset of decreased postural alignment and decrease in strength. The notes did not reference the use of a dycem.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of OT Treatment Encounter Note(s) from 2/11/25 to 2/25/25 included training repositioning in wheelchair to patient and caregiver, training to nursing on positioning and in wheelchair and locking leg rests into place. The note dated 2/18/25 included instruction to patient in proper body mechanics, safety precautions and self care/skin checks specifically, in order to increase functional mobility skills and increase safety and decrease need for assistance with partial carryover demonstrated during training, due to safety awareness and patient's comprehension skills.<br><br>On 2/28/25 at 12:03 PM, RN A stated fall prevention interventions for resident #51 included close/frequent supervision, every 15 minutes. She indicated resident #51 participated in activities or stayed in the TV room where the staff kept an eye on her. She stated nurses, CNAs and therapy would be responsible to ensure the dycem was on resident #51's wheelchair before the resident was transferred to it. She indicated she did not recall if the dycem was in her wheelchair today. She mentioned resident #51 was working with OT.<br><br>On 02/28/25 at 12:23 PM, CNA N stated today was the first day by herself on her first assignment. She explained she had a 2-day orientation then shadowed on the floor for 3 days. She shared she received report about her assigned residents this morning. She indicated she did not recall reviewing the Kardex during her training. She stated she did not recall seeing a dycem in resident #51's wheelchair when she was transferred this morning. CNA N asked, Is the resident supposed to have it?<br><br>On 2/28/25 at 12:56 PM, MDS Coordinator L validated interventions included in the fall investigation packet were not all included in the care plan. She reviewed the care plan and stated she saw offering the resident afternoon naps and to keep in in a common area for supervision. She stated she was surprised the increased supervision intervention was not there. She indicated everyone knew resident #51 and everyone kept an eye on her.<br><br>On 2/27/25 at 3:43 PM, the DON explained once a fall investigation was completed, the MDS Coordinator attending the meeting added new interventions to the care plan. Later on 2/28/25 at 2:10 PM, the DON stated the UM was responsible for communicating with the CNAs before they started their assignments. She indicated her expectation was the nursing staff communicated any new interventions to each other and the care plan was updated with the appropriate interventions.<br><br>Review of the policy titled Accidents and Supervision reviewed on 3/01/23 read, The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. The guidelines mentioned potential hazards and risks would be documented and communicated across all disciplines. The implementation of interventions included communicating the interventions to all relevant staff, documenting interventions, and ensuring the interventions were put into action. The policy revealed the facility would provide adequate supervision to prevent accidents. The form read, Adequacy of supervision: Defined by type and frequency. Based on the individual resident's assessed needs and identified hazards in the resident environment.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the policy titled Comprehensive Care Plans revised on 1/01/23 read, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs that are identified in the resident's comprehensive assessment. The guidelines revealed the care planning process included an assessment of the resident's strengths and needs, incorporating the resident's personal and cultural preferences in developing goals of care. The form read, Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40892<br><br>Based on observation, interview, and record review the facility failed to provide an ongoing program of activities to meet the needs and interests of 1 of 5 residents reviewed for activities, of a total sample of 59 residents, (#58).<br><br>Findings:<br><br>Resident #58 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia, hypertension, and open-angle glaucoma with borderline findings.<br><br>The Minimum Data Set (MDS) Annual assessment, with an assessment reference date of 1/14/25, revealed resident #58 had a Brief Interview for Mental Status of 12/15, which indicated mild cognitive impairment. The MDS revealed that resident #58 was visually impaired and required large print in newspapers and books but not regular print.<br><br>A review of the resident's comprehensive care plan revealed the resident's activities should be compatible with physical and mental capabilities, such as large print holders, if the resident lacked hand strength and task segmentation.<br><br>On 2/25/25 at 9:52 AM, Activity Aide R was observed as they entered resident #58's room, handed the resident a red bag, and left the room. The resident opened the bag and removed the items. The bag contained a regular print sudoku puzzle book and a coloring book. Resident #58 expressed frustration as she explained she could not see what was in those books. She stated, I cannot see in these books; my eyes are no good, and glasses do not help. There was no other activity for resident #58 at that time.<br><br>On 2/26/25 at 9:45 AM, resident #58 was observed standing holding onto the door of her room; there were no activities going on for her.<br><br>On 2/27/25 at 9:33 AM, resident #58 was observed along with the Activity Director. The resident was sitting on the bed, and no activity was ongoing. The resident stated she gave the books to the lady, pointing to the room mate, lying in bed B. The Activity Director acknowledged that the suduko book and coloring book the resident received for the activity did not meet the resident's needs. Resident #58 should have received large print books compatible with her physical and mental capabilities.<br><br>Review of the facility's assessment dated [DATE], revealed, The care required by the resident population using evidenced-based, data-driven methods that consider the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessment. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51234<br><br>Based on interview, and record review, the facility failed to have ongoing communication and collaboration with the dialysis facility regarding dialysis care and services for 1 of 1 sampled residents who receive hemodialysis, of a total sample of 59 residents, (#12).<br><br>Findings:<br><br>Review of resident #12's medical record revealed an admitted [DATE]. His Quarterly Minimum Data Set, dated dated dated [DATE] indicated a Brief Interview of Mental Status score of 5/15, which indicated moderate cognitive impairment. His diagnoses included: end stage renal disease, dependence on renal dialysis, and unspecified dementia with unspecified severity, without behavioral disturbance.<br><br>Review of resident #12's medical record revealed physician's orders dated 4/16/24 for hemodialysis to occur on Monday, Wednesday, and Friday at Dialysis Center #1.<br><br>Review of resident #12's medical record revealed no documentation of communication having occurred between staff from Dialysis Center #1 and the facility nursing staff from 1/01/25 to 2/25/25.<br><br>On 2/26/25 at 2:30 PM, the South Subacute Unit (SSU) Unit Manager (UM) said that she expected the facility's Dialysis Communication Record to be completed by the facility's nursing staff and for the form to be sent with the resident when he attended a dialysis treatment at Dialysis Center #1. She said nursing staff should then review the form from the dialysis center upon his return, and include it into his medical record. The UM verified there were no Dialysis Communication Records nor any other communication documentation with Dialysis Center #1 in the resident's paper medical record maintained on the Unit.<br><br>A few minutes later on 2/26/25 at 2:40 PM, the SSU UM continued that if the Dialysis Communication Record was not returned from Dialysis Center #1 then she expected resident #12's assigned nurse to call Dialysis Center #1 upon resident #12's return or by the next day to receive an update on resident #12's condition. The UM described information needed by the facility included vital signs, weights, pain level, lab values, or medications provided during the dialysis session, and nurses should then obtain the previous Dialysis Communication Record on the next dialysis treatment.<br><br>On 2/27/25 at 8:07 AM, telephonically spoke with Clinical Manager #1 of Dialysis Center #1 and he stated that the facility used to send a binder for communication to be documented in but he hasn't seen that in awhile. He said resident #12 has been receiving hemodialysis services with them since January 2023. He recalls speaking with facility staff, but not after every dialysis session.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/27/25 at 8:27 AM, telephonically spoke with Clinical Nurse #1 of Dialysis Center #1 who said he has spoken with a facility staff person when for example they call to say resident #12 arrived late for his session. He confirmed facility nurses did not call him after every session for an update on resident #12's post treatment condition. He recalled that in the past six months resident #12 had been late to one scheduled session. He stated that the facility used to send a binder that communications would be documented in and returned with resident #12 to the facility but it had been six months or more since he had seen that binder nor any other kind of communication document. He described that sometimes it was difficult to get in touch with resident #12's nurse at the facility. He explained that the front desk would transfer his call but there would be no response after the transfer or he would have to leave a message with the front desk.<br><br>On 02/27/25 at 1:25 PM, the Assistant Director of Nursing (ADON) said that communication with resident #12's dialysis facility was important to coordinate care for him-such as to know if there were any changes in his condition during the session or any post session follow-up. She said if the Dialysis Communication Record was not returned from Dialysis Center #1 she would expect the facility's nurse to call Dialysis Center #1 after the session and document any updates in his condition in his facility medical record or call and request the Dialysis Communication Record to be faxed to the facility. The ADON verified there was no documentation from 1/02/25 to 1/25/25 of the Dialysis Communication Records in his electronic medical record nor was there documentation that facility nurses called Dialysis Center #1 post dialysis treatment for the information. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192<br><br>Based on observation, interview and record review, the facility failed to accurately document the administration of medications in the Medication Administration Record (MAR) for 1 of 3 residents reviewed for pain, of a total sample of 59 residents, (#18).<br><br>Findings:<br><br>Review of resident #18's medical record revealed he was readmitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus, Alzheimer's disease, dementia, and osteoarthritis of knee.<br><br>Review of resident #18's Minimum Data Set (MDS) quarterly assessment with Assessment Reference Date (ARD) of 1/27/25 revealed a Brief Interview for Mental Status (BIMS) score of 5/15, which indicated he was cognitively impaired. The MDS assessment noted no rejection of evaluation or care necessary to obtain his goals for health and well-being.<br><br>Review of resident #18's medical record revealed a care plan for acute/chronic pain related to disease process and general discomfort revised on 9/05/22. The interventions directed nurses to administer analgesia per orders and to Monitor/document for side effects of pain medication.<br><br>Review of resident #18's physician orders revealed an order for Tylenol 325 milligrams (mg) dated 9/05/24. The order instructed the nurses to give 2 tablets every 6 hours as needed for pain.<br><br>On 2/25/25 at 12:07 PM, resident #18 complained of pain on his left wrist. He stated his pain level was 10 out of 10 while holding his left wrist with his right hand. He mentioned he told the nurse but had not received anything for the pain.<br><br>On 2/25/25 at 12:09 PM, Certified Nursing Assistant (CNA) J entered the room because the call light was on and told resident #18 she informed the nurse. When asked how long ago she informed the nurse, CNA J answered about 5 minutes ago.<br><br>On 2/25/25 at 12:11 PM, Registered Nurse (RN) D entered the room with a medication cup in her hands. RN D informed resident #18 she brought him two Tylenol for his pain. CNA J entered the room at 12:15 PM and assisted RN D to sit resident #18 up and he took the two pills. Resident D did not assess his pain level or location of the pain.<br><br>Review of the MAR for February 2025 revealed Tylenol was documented as administered once on 2/17/25 and on 2/18/25. There was no documentation in the MAR of the Tylenol given by RN D on 2/25/25.<br><br>Review of resident #18's progress notes revealed no note entered on 2/25/25 by RN D regarding his pain or the Tylenol given.<br><br>On 2/27/25 at 11:11 AM, RN D stated she did not work the day before (2/26/25) and could not now recall why she did not document the Tylenol as given on 2/25/25.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/27/25 at 12:00 PM, the General & Restorative Unit Manager (UM) shared her responsibilities included ensuring documentation was completed by the nurses. The UM stated she did not see Tylenol documented as given on 2/24/24. She indicated accurate documentation was important, it was the expectation and Nursing 101.<br><br>On 2/27/25 at 2:53 PM, the Director of Nursing stated she expected nurses to document medications administered and their effectiveness accurately.<br><br>Review of the facility's policy entitled Charting and Documentation revised in July 2017 read, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychological condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The form listed the information to be documented in the medical record, including medications administered. Documentation in the medical record will be objective . , complete and accurate.<br><br>Review of the facility's policy titled Medication Administration revised on 6/01/24 revealed licensed nurses were to sign the MAR after administration of the medication. The form indicated for medications requiring vital signs, record vital signs onto the MAR. |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192<br><br>Based on interview, and record review, the facility failed to maintain effective communication between nursing staff and hospice to promote adequate treatment, monitoring, and continuity of care for 2 of 2 residents reviewed for hospice care and services, out of a total sample of 59 residents, (#3 and #469).<br><br>Findings:<br><br>1. Review of resident #3's medical record revealed she was originally admitted to the facility on [DATE] and readmitted from a short-term, acute hospital on 8/14/24. Her diagnoses included senile degeneration of brain, type 2 diabetes, dementia, glaucoma, bilateral hearing loss, and congestive heart failure.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of 12/10/24 revealed resident #3's Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated severe cognitive impairment. The MDS assessment showed resident #3's was receiving hospice care.<br><br>Review of resident #3's comprehensive care plan revealed a focus of hospice care related to terminal prognosis initiated on 9/06/24. The interventions included coordinating care plan with hospice and notifying hospice of any change in condition or medication changes.<br><br>Review of resident #3's medical record revealed the following Change in Condition Evaluation forms:<br><br>*2/18/25 fall with injury, bump on forehead<br><br>*2/13/25 Bruise in left eye and swelling<br><br>*2/12/25 fall with no injury<br><br>The forms included documentation the physician and resident's representative were notified but did not include notifying hospice.<br><br>Review of resident #3's Progress Notes revealed the following:<br><br>*2/12/25 - The CNA (Certified Nursing Assistant) observed the resident on the toilet floor. The resident was attempting to transfer to the toilet without assistance and fell to the floor . denied any pain or discomfort . Physician notified. Family notified. Neurological monitoring began at 5:15 [PM] and will continue to be monitored for any changes.<br><br>*2/14/25 - Resident #3 was sent by ambulance to the hospital for a CT (Computed Tomography) Scan of the head as ordered by the facility's physician.<br><br>(continued on next page) |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | *2/14/25 - Resident #3 returned from the hospital around 6:30 pm. Left eye bruise noted. Per hospital paperwork, labs and imaging show no signs of brain bleeds, no signs of head or neck fractures. Resident's daughter was in the room when resident came back from hospital.<br><br>*2/18/25 - 911 was called, resident fell and large bump noted. Nurse called the facility's physician who ordered the resident be transferred to the hospital for evaluation, the supervisor on duty, and resident #3's daughter were notified.<br><br>On 2/27/25 at 1:12 PM, the General & Restorative Unit Manager (UM) stated falls were discussed every morning during clinical meetings by the Interdisciplinary Team (IDT). She explained the IDT reviewed the incident report, looked for any type of injuries, and discussed any new interventions required after reviewing the care plan. She indicated she expected the nurses to call hospice about any issues or changes in conditions on hospice residents. She would expect the nurses to document notification to hospice, the physician and the family in Change in Condition Evaluation form or in a progress note. She indicated she did not verify if the nurses communicated the changes in condition to hospice.<br><br>On 2/27/25 at 3:48 PM, the Director of Nursing stated nurses were expected to document any communication with the hospice nurse. She indicated anything that happened to a resident receiving hospice services was called to hospice and documented in the medical record.<br><br>On 2/28/25 at 8:38 AM, during a telephone interview, Hospice Registered Nurse (RN) O explained she visited resident #3 at least every other week. She indicated when a resident fell , the facility would be expected to take any necessary immediate action, like sending a resident to the hospital, if required. She stated hospice was not always informed at that moment, but the expectation was the facility informed hospice as soon as possible after the change in condition was identified. She indicated she learned through the hospice CNA on 2/14/25 about resident #3's bruise and that she was taken to the hospital. She shared the facility did not always notify them of resident #3's changes. Later on 2/28/25 at 9:18 AM, RN O shared she looked through their triage notes and found no calls from the facility informing them about resident #3's falls, bruise or transfer to the hospital. RN O stated she learned the details of the 2/12/25 fall during her visit to the facility on [DATE]. She indicated they did not receive a call reporting the fall on 2/18/25 either.<br><br>Review of the facility's policy titled Coordination of Hospice Services dated 1/01/23 read, when a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental, and psychological well-being. The Guidelines read, The facility will immediately contact and communicate with the hospice staff, attending physician/practitioner and the family resident representative regarding any significant changes in the resident's status, clinical complications or emergent situations.<br><br>Review of the Nursing Facility Services Agreement between [name of hospice provider] and the facility dated 11/29/12 read, The Nursing Facility shall notify Hospice when the Hospice Patient experiences a change of condition and shall notify the Hospice Patient's attending physician and family of significant change in condition.<br><br>50875<br><br>(continued on next page) |

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| | 106011 | A. Building<br>B. Wing | 02/28/2025 |

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| Kissimmee Nursing & Rehabilitation Center | 2511 John Young Parkway North<br>Kissimmee, FL 34741 |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Review of the electronic medical record revealed resident #469 was admitted to the facility on [DATE] and discharged on [DATE]. Some of her medical diagnoses included chronic kidney disease, unspecified dementia, chronic obstructive pulmonary disease, bipolar disorder, type 2 diabetes, heart failure and insomnia.<br><br>According to the most recent Annual MDS assessment dated [DATE], resident #469 had impaired cognition with a BIMS score of 4 out of 15, which indicated severely impaired cognition. The assessment indicated resident #469 utilized a wheelchair for mobility, had a life expectancy of less than six months, and was admitted to the care of Hospice provider #2's care on 11/28/23.<br><br>On 2/25/25 at 5:21 PM, in a telephone interview, resident #469's granddaughter explained she was informed about her grandmother's fall and fractured hip on 1/15/25 by the hospice nurse and wanted her grandmother to be transferred to the hospital. She revealed that her grandmother was declining and she passed away on 1/21/25. Resident #469's granddaughter said that the facility never informed her nor any other family members that her grandmother had fallen.<br><br>On 2/26/25 at 9:55 AM, in a telephone interview, Hospice provider #2's Nurse Case Manager Registered Nurse (RN) F said she was assigned to resident #469 since April 2024. She explained that on 1/15/25 she received a call from the Hospice Social Worker who informed her that resident # 469 was screaming in pain and had learned that the resident had fallen a few days before. RN F said she headed out to see the resident after the phone call and on arrival, resident #469 was on her bed, yelling, with her leg flexed upward. RN F recalled resident 469's right hip and thigh was swollen and she was more anxious. She discovered the resident had fallen on 1/10/25 and the results from an x-ray completed just a few hours before she got there indicated a right hip fracture. RN F also received orders for an increased dosage of morphine, medicated the resident, and informed the resident's granddaughter immediately who then requested for the resident to be sent to the emergency room . RN F explained she had seen the resident the day before on 1/14/25 but was not informed of the fall. She explained resident #469 was within normal limits during her assessment on 1/14/25. She recalled that on 1/11/25 a Hospice after-hours nurse also saw the resident for increased anxiety, insomnia, yelling and screaming out but was not made aware of the fall.<br><br>On 2/26/25 at 11:10 AM, via telephone call Advent Health Hospice Social Worker said that on 1/15/25 she was visiting another resident and as she passed by resident #469's room, she saw the resident's right leg hanging off the bed and she was yelling out. She then went to the Director of Nursing (DON) to assist her with positioning resident #469 in the bed so that her leg was not hanging off to the side of the bed. The DON told her that the resident had fallen last week and that the hospice nurse RN F, was informed. The Hospice Social Worker said she immediately called RN F and the Hospice Supervisor, and both confirmed they had not been informed the resident fell on [DATE].<br><br>A review of the medical record showed documentation on 1/10/25 at 3:24 PM, by RN A which described, A noise is heard in the hallway of #200. When arriving, the resident is seen on the floor in front of the room. The skin is checked, no wound is seen. She states that she is not in pain at the moment. She is transferred to a wheelchair and a 2-liter oxygen cannula is placed. [The physician] is notified, and he gives medical orders and calls family members.<br><br>On 2/26/25 at 10:42 AM, via telephone, RN A confirmed her documentation as she recounted the events which took place on the day the resident fell . She said that she did not call Hospice and that the Unit Manager (UM) for the General and Restorative (G and R) unit was the one who called Hospice.<br><br>(continued on next page) |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/26/25 at 2:49 PM, the UM for the General & Restorative Unit recalled the day resident #469 fell and gave an outline of the event. She acknowledged she did not call hospice provider #2 to inform them about the incident and stated that RN A was the one who called the physician, the family and hospice. The UM said that the communication between the nurse and the hospice should have been documented, however, she could not show any documentation of this notification in the resident's electronic medical record.<br><br>A review of hospice provider #2's and the Skilled Nursing Facility Integrated Plan of Care dated 11/29/23 and 11/30/23 under the section, Assessment/Nursing Care, it detailed the facility nurse was to provide services required by plan of care and notify hospice regarding changes in patient status, comfort level and /or new orders.<br><br>On 2/27/25 at 3:48 PM, the Director of Nursing (DON) stated the facility nurse should communicate with the hospice nurses. Her expectation was for nurses to call hospice at any time for any change in condition, skin tear, falls, etc. then to document the communication. The DON said going forward, she also wanted to be notified if a resident fell , in addition to the family, the physician, and hospice.<br><br>A review of the Facility's Policy on Coordination of Hospice Services implemented on 1/01/23 revealed in section 10, The facility will immediately contact and communicate with the hospice staff, attending physician/practitioner and the family resident representative regarding any significant changes in the resident's status, clinical complications or emergent situations. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>50875<br><br>Based on observation, interview, and record review during the medication administration task, facility staff failed to disinfect the blood pressure monitor between residents for 1 out of 5 residents reviewed for medication administration, of a total sample of 59 residents, (#1).<br><br>Findings:<br><br>On 2/25/25 at 10:09 AM, during the Medication Administration task, it was observed that Registered Nurse (RN) D used a portable blood pressure monitoring device to take the blood pressure of resident #98. She then proceeded to the next resident #1 for medication administration. She did not disinfect the blood pressure monitor after using it for resident # 98, nor before using it on resident #1. RN D explained that she was stressed and had forgotten to clean the device between residents as she was supposed to.<br><br>On 2/28/25 at 9:46 AM, the Infection Preventionist (IP) said that the purple top wipes were used to disinfect equipment for one minute and they always tried to follow the manufacturer's drying and contact times. She described that facility staff recently had an in-service concerning sanitizing the vital sign machines. The IP explained she would often conduct audit checks with staff, but was unable to explain why RN D did not disinfect the blood pressure monitoring device between use on the two residents. She said her expectation would be that staff cleaned equipment every time between residents which was important to prevent infections received from cross contamination. The IP provided evidence of a recent inservice dated 10/28/24 to 11/24 to clean/sanitize equipment between use of each resident with germicidal wipes (purple top) but RN D had not signed that inservice.<br><br>On 2/27/25 at 2:53 PM, the Director of Nursing (DON) explained the expectation was that staff would clean the blood pressure monitoring device, or any equipment used between residents to avoid cross contamination.<br><br>A review of the facility's policy on Cleaning and Disinfection of Resident Care Items and Equipment Revised September 2022 revealed, Resident Care Equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC (Centers for Disease Control) recommendations for disinfection and the OSHA (Occupational Safety and Health Administration) Bloodborne Pathogens Standard. |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement a program that monitors antibiotic use.<br><br>51234<br><br>Based on record review, and interview, the facility failed to develop a comprehensive system to monitor antibiotic use in the facility from January 2025 through the time of the survey.<br><br>Findings:<br><br>Review of the Infection Control Report dated 1/01/25 to 1/31/25 included the Infection Surveillance Monthly Report dated 1/01/25 to 1/31/25 which revealed in the Summary by Infection Category that there was 1 Urinary Tract/Kidney infection that occurred with a resident, #23.<br><br>Review of the Order Listing Report dated 01/01/25 to 01/31/2025 which included antibiotic medication classes revealed residents #99, #53, #87, and #20 were also receiving antibiotics in January 2025 for urinary tract/kidney infections.<br><br>Review of resident #99's medical record revealed an order dated 1/07/25 for a urinalysis. The urinalysis lab report indicated a collection and report date of 01/09/25. There was no culture and sensitivity testing that followed the 1/09/25 urinalysis. A physician's order with a start date of 1/14/25 stated to give Levaquin 500 milligrams (mg) 1 tablet by mouth one time a day for a urinary tract infection (UTI) for 5 days.<br><br>Review of resident #53's medical record revealed an order dated 1/31/25 for Ciprofloxacin HCl (an antibiotic) 500 mg, one tablet to be taken by mouth twice daily for a UTI for seven days. The facility's medication administration record indicated this medication was administered starting 1/31/25 and the Order Listing Report for 01/01/25 to 01/31/25 indicated the course of antibiotics was completed.<br><br>Review of resident #87's medical record revealed an order dated 1/31/25 for Cefuroxime Axetil (also known Ceftin-an antibiotic) 500 mg by mouth two times a day for pyelonephritis for seven days. The facility's medication administration record indicated that this medication was administered starting 1/31/25 and the Order Listing Report for 1/01/25 to 1/31/25 indicated it was completed.<br><br>Review of resident #20's medical record revealed on 1/23/25 hospital discharge orders for Ceftin (an antibiotic) 500 mg one dose in morning and one dose before bedtime for all 10 doses. This discharge summary dated 1/23/25 indicated it was prescribed related to a UTI. The facility's medication administration record revealed the Cefuroxime Axetil (also known as Ceftin-an antibiotic) 500 mg one dose in the morning and one at bedtime for 10 doses were given 01/24/25 to 01/29/25.<br><br>On 2/27/25 at 12:13 PM, the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) said she did not do a look back between months to analyze if residents have repeated infections. She also said she had not assessed residents' antibiotic use regarding if there were physician trends in prescribing.<br><br>(continued on next page) |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/28/25 at 1:15 PM, the ADON/IP stated she usually reviewed urinalysis labs ordered by physicians to analyze if culture and sensitivities had been included in the order because such an additional test would reveal if the ordered antibiotic was appropriate treatment for the organism identified. She confirmed she overlooked resident #99's 1/09/25 urinalysis which did not include a culture and sensitivity analysis. She verified that resident #99 was prescribed and received an antibiotic course after the urinalysis dated 1/09/25 results were reported.<br><br>On 2/28/25 at 2:55 PM, the ADON/IP stated that when a resident started receiving an antibiotic the resident should appear on that month's Infection Control Report which she said she submitted monthly during the facility's Quality Assurance meeting which included participation of the facility's Medical Director. She reviewed the Infection Control Report dated 1/01/25 to 1/31/25 and compared it to the Order Listing Report with antibiotic classes for 1/01/25 to 1/31/25. The IP verified that residents #99, #53, #87, and #20 were not a part of the Infection Control Report dated 1/01/25 to 1/31/2025 and they should have been.<br><br>Review of the facility's infection surveillance policy with a date reviewed/revised of 6/01/24 indicated all residents and their infections would be tracked.<br><br>Review of the facility's antibiotic stewardship commitment statement dated 2/10/25 and signed by the Administrator, Director of Nursing (DON), Medical Director, IP, and consultant pharmacist stated that they would collaborate with prescribers, nurses, and the consultant pharmacist to create a system that monitored and shared reports regarding antibiotic use in the facility. |